

1 MARCO HEYWARD  
2 P.O. BOX 466  
3 HAYWARD, CA. 94543  
4 (510) 781-1511 P 4:14

5 RICHARD W. WICKING  
6 CLERK, U.S. DISTRICT COURT  
7 NORTHERN DISTRICT OF CALIFORNIA

8 MARCO HEYWARD, PRO SE

9 FILED (3)

10 2014 NOV 19 P 12:49 PM

11 RICHARD W. WICKING  
12 CLERK, U.S. DISTRICT COURT  
13 NORTHERN DISTRICT OF CALIFORNIA

14 UNITED STATES DISTRICT COURTS  
15 NORTHERN DISTRICT OF CALIFORNIA

KAW

16 MARCO HEYWARD

17 CV 14 5114

18 ) Case No.:

19 Plaintiff,

20 ) MEDICAL COMPLAINT FOR DAMAGES  
21 ) UNDER DUTY OWED OF  
22 ) RESPONSIBILITY AND OBLIGATION

23 vs.

24 United States Government  
25 NAME OF DEFENDANT,

26 Defendant

27 PLEASE TAKE NOTICE that on November 16, 2011, Plaintiff filed an Administrative Tort Claim/  
28 Complaint with the "state entity" The San Francisco Regional Counsel's Office using the Standard  
Form 95 (SF-95) for MEDICAL MALPRACTICE, "OWED DUTY OF STANDARD CARE" in a  
timely manner, giving THE DEPARTMENT OF VETERANS AFFAIRS REGIONAL OFFICE OF  
OAKLAND, CA.94612 and VA Medical Hospital , 4150 Clement Street, San Francisco, CA. 94121  
an opportunity to settle and provide me with a revised surgery of my left quadriceps tendon where  
they placed my left knee anatomically lower than my right knee before suit was brought, and an

opportunity to make an investigation of the facts. (SEE ATTACHMENT A/FORM 95 AND TORT  
CLAIM).

1

The Department of Veterans Affairs is a corporation or unincorporated or unincorporated association and its principal place of business is located in Alameda County.

III

Plaintiff has complied with the statute of limitations and files this complaint according to  
Government Code Section 12965, subdivision (b).

III

Defendants violated Plaintiffs Civil Rights under 38 U.S.C. Chapter 11(COMPENSATION), Extraordinary relief, Restitution of Remedies 28 U.S.C. 2674 (LIABILITY OF UNITED STATES), Civ. Code 3294 (a) (MALICE), and Hospital Negligence.

IV

## **FIRST CAUSE OF ACTION**

38 U.S.C. 1151:

On December 28, 2010, Plaintiff underwent arthroscopic surgery of my right and left bilateral quadriceps tendons. (SEE ATTACHMENT B/PHOTOS). It was noted by x-rays on March 14, 2011 that the surgical team of Hubert Kim, M.D., office: 4150 Clement St., San Francisco, CA. 94121, and Nancy Kadel, M.D., office: 4150 Clement St., San Francisco, CA. 94121, provided Plaintiff with inadequate medical care, because the defendants knew/had knowledge that my

1 left knee was surgically placed anatomically lower than my right  
2 knee. (SEE ATTACHMENT C/DISABILITY INDEMNITY SUPPLEMENTAL REPORT).  
3 On May 19, 2011, Nurse Practitioner, Betty King reveal through x-  
4 rays, physical examinations, and physical therapy assessments that  
5 I re-ruptured my left quad tendon as a result of physical therapy  
6 and the positioning of my left knee. (SEE ATTACHMENT  
7 D/SUPPLEMENTARY STATEMENT). As a result of this knowledge the VAMC  
8 San Francisco recklessly tried to shift the blame to Plaintiff  
9 alleging noncompliance which is an extreme departure from ordinary  
10 standard of care. Thus, as a result Plaintiff has additional  
11 disability as a result of carelessness, negligence, error in  
12 judgment, and malice. Since services rendered by the VA, Plaintiff  
13 has filed an application for additional disability compensation and  
14 related compensation benefits because the VA was the proximate  
15 cause of these additional and secondary disabilities for left thigh  
16 muscle atrophy, depression, left knee/right knee and lower back .  
17  
18 (SEE ATTACHMENT E/FORM 21-526EZ).  
19

20  
21 V  
22

23 SECOND CAUSE OF ACTION  
24  
25  
26  
27  
28

**MALICE**

**Civ. Code 3294 (a) (MALICE)**

The VAMC San Francisco and the Department of Veterans Affairs conduct and willful knowledge of the surgically placement of my left knee and the re-rupturing/separation of my left quad tendon refused to provide Plaintiff with equal standard of care. The Department of Veterans Affairs, after diligently and rigorously finally decided on September 9, 2013 arranged an Orthopedic Surgery Consult with Dr. Nicholas Giori at the Palo Alto VAMC, where he ruled out a revised surgery due to the lapse of time and that my condition is permanent. (SEE ATTACHMENT F/ PROGRESS NOTES).

VI

### THIRD CAUSE OF ACTION

### (Intentional Tort)

**Extraordinary relief, Restitution of Remedies 28 U.S.C. 2674 (LIABILITY OF UNITED STATES).**

That the series of events which were narrated on the first cause of action, and second cause of action and which are hereby adopted and made part of this third cause of action. That the Defendants by their conduct and manner, who were acting in their individual capacity, which constitutes a cause of action of Defendants intentional tort actions and caused to Plaintiff. Stated and narrated in the first cause of action, second cause of action, third cause of action which adopted, did in fact suffer emotional distress and diminished quality of life which were the result of Defendants malicious acts.

Wherefore, premises considered, Plaintiff prays of this Honorable Court for judgment: Ordering Defendants, to pay Plaintiff damages and actual loss as may be proven during the trial and which can be conservatively estimated to be in the amount of **FORTY MILLION DOLLARS (\$40,000,000.00)**

The costs of having to be forced to initiate this action to vindicate Plaintiffs' violated rights; and for

1 such further relief as the court may deem just, proper and equitable, in the interest of justice.  
2 Therefore, Plaintiff request's the UNITED STATES DISTRICT COURT, NORTHERN DISTRICT  
3 OF CALIFORNIA to accept this Medical Complaint and more forward.  
4  
5  
6  
7

8 **I DECLARE UNDER PENALTY THAT THE FOREGOING IS TRUE AND CORRECT.**  
9  
10  
11  
12 DATED: November 18, 2014  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

  
MARCO HEYWARD  
Pro SE

**ATTACHMENT**

**A**





DEPARTMENT OF VETERANS AFFAIRS

Regional Counsel  
4150 Clement Street  
San Francisco, CA 94121  
Tel (415) 750-2288  
Fax (415) 750-2255

November 21, 2011

Mr. Marco B. Heyward  
P.O. Box 466  
Hayward, CA 94543

**Re: Administrative Tort Claim of Marco B. Heyward**

Dear Mr. Heyward:

This letter acknowledges receipt by this office of a Standard Form 95 (SF-95), "Claim for Damage, Injury, or Death," asking for \$1,000,000.00 in damages. The San Francisco Regional Counsel's office received your claim on November 16, 2011. The SF-95 alleges medical malpractice. Accordingly, by federal statute, the VA has six months within which to investigate the claim. I am in the process of requesting your VA medical records. After receipt of said records, we will commence the investigation. A date-stamped copy of the claim is enclosed for your records.

In order to evaluate this case, the attorney assigned to this case, Janice Bressler, will need additional information. This information should be sent to her address at: Department of Veterans Affairs, Office of Regional Counsel, 4150 Clement Street, San Francisco, CA 94121. Should you have any questions, she can be reached at: 415-750-2288. Pursuant to 28 C.F.R. Section 14.4, documentation concerning the following areas must be submitted in support of your claim:

1. Names and addresses of all private physicians who have examined or treated you for the injuries or disabilities alleged to be a result of our negligence;
2. If a private physician is currently treating you, a written report by that attending physician setting forth the nature and extent of the injury or condition, nature and extent of treatment, any degree of temporary or permanent disability, the prognosis, period of hospitalization, and any diminished earning capacity;
3. Itemized bills for medical and hospital expenses that you have incurred, or itemized receipts of payment for such expenses;
4. If there will be a necessity for future treatment, a statement of expected expenses for such treatment;
5. If the prognosis reveals the necessity for future treatment, a statement of expected expenses for such treatment;

6. If a claim is made for loss of time from employment, a written statement from your employer showing the actual time lost from employment, whether you are a full or part-time employee, and wages or salary actually lost;

7. If a claim is made for loss of income and you are self-employed, documentary evidence showing the amount of earnings actually lost;

8. Medical documents supporting your contention that your treatment by VA was negligent; and

9. Any other evidence or information which you believe may have a bearing on the alleged responsibility of the United States for the damages claimed by you.

I am enclosing medical release forms which you can complete so that we can obtain your non-VA medical records directly from your physicians who have treated you for the disabilities alleged to be a result of our negligence. Please return the completed forms to us so that we may begin our investigation of the claim.

Your assistance in providing the information requested is greatly appreciated.

By filing a Standard Form 95 with our office, you have initiated a tort claim investigation. However, depending upon the facts of your claim you may be eligible for VA benefits. I enclose for your information a brochure which describes the differences between a tort claim and a benefits claim and how each kind of claim is processed.

Sincerely yours,



ALI ATKINSON  
Paralegal

Enc.

**ATTACHMENT**

**B**

RIGHT KNEE.



LEFT KNEE.



**ATTACHMENT**

**C**

05-18-'11 15:22 FROM-

T-324 P0003/0004 F-762

A&H Claims Department  
 P. O. Box 25987  
 Shawnee Mission, KS 66225-5987  
 800-551-0824

NAME OF GROUP: Gencon Volunteer Labor  
 #9019830  
 POLICY NUMBER:

## DISABILITY INDEMNITY SUPPLEMENTAL REPORT

## INSTRUCTIONS:

- 1.) Section A must be completed in full by claimant.
- 2.) Section B must be completed in full by Attending Physician.
- 3.) This form must be signed and dated in all applicable sections.
- 4.) This form must be submitted to the address indicated above.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

## SECTION A- CLAIMANT'S STATEMENT (Please Print or Type)

Claimant's Full Name Marco Barren Heyward Telephone Number (510) 677-5151  
 First Middle Last

Address 2100 65<sup>th</sup> Ave Oakland, CA 94621  
 Number Street City or Town State Zip Code Apt #

On what date(s) since the last statement furnished by you were you treated by a physician? \_\_\_\_\_

Names and addresses of current attending physicians:

Physician's Name: Hubert Reim MD

Office Address: 4150 Clement St. San Francisco CA 94121  
 Number Street City State Zip Code

Physician's Name: Dency Kadel MD

Office Address: 4150 Clement St., San Francisco CA 94121  
 Number Street City State Zip Code

Have you returned to work? No If yes, on what date? \_\_\_\_\_

If not, when do you expect to return? June 2011

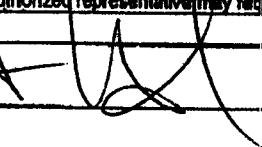
For what period were you continuously disabled? From 12/28/11 Through 6/30/2011

Have you retired from your business or occupation? No If yes, when? \_\_\_\_\_

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

## AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

SIGNATURE: DATE: 5/19/11

**ATTACHMENT**

**D**

05-18-'11 15:23 FROM-

T-324 P0004/0004 F-762

## SECTION B- ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Claimant's Name: Marco Barron Hayward  
Please answer all questions

1. Nature of sickness or injury and complications, if any, causing disability? Bilateral quadriceps tendon rupture

2. What operations, if any, were performed since last statement? Repair bilateral Quads Tendon

3. Give all dates of treatment since last statement: Home \_\_\_\_\_ Office 3/23/11, 2/14/11

4. Was claimant hospitalized since last statement? No From \_\_\_\_\_ To \_\_\_\_\_

Name and Address of Hospital: \_\_\_\_\_

5. Have any other physicians been in attendance or consultation since last statement? Yes  
If yes, give their names and addresses: Dr Erik Hansen - Resident - 5

6. Current limitations and restrictions, if any: Left patellar infera, Partial re-rupture of Quad tendon

7. Is this claimant totally disabled from each and every occupation? No  
If no, please explain: Weight bearing as tolerated w/Ringed Knobbrace locked in extension, PT at 60° flexion under supervision increase 13 day / 2 wks

8. (a) How long was or will claimant be totally disabled from current occupation? From \_\_\_\_\_ To \_\_\_\_\_  
(b) How long was or will claimant be partially disabled from current occupation? From \_\_\_\_\_ To \_\_\_\_\_  
(c) Estimated return to work date: \_\_\_\_\_

9. What is the prognosis? Good

Doctor's Signature DR. B. KlineDate 5/19/11Doctor's Name (please print or type) Betty Kline NP

Tel. #(415) 221-4410 X 4766

Office Address 4150 Clement St., San Francisco CA 94121  
Number 4150 Street Clement St. City or Town San Francisco State CA Zip Code 94121

**ATTACHMENT**

**E**



Department of Veterans Affairs

APPLICATION FOR DISABILITY COMPENSATION  
AND RELATED COMPENSATION BENEFITS

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 8 before completing the form.

VA DATE STAMP  
(DO NOT WRITE IN THIS SPACE)  
RECEIVED  
PUBLIC CONTACT  
VETERANS AFFAIRS

16 SEP 12 PM 2:29

## SECTION I: IDENTIFICATION AND CLAIM INFORMATION

1. VETERAN/SERVICE MEMBER NAME (Last, first, middle)	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH (MM,DD,YYYY)					
Heyward, Marc	092-58-7776	02, 24, 1944					
4. SEX	5. HAVE YOU EVER FILED A CLAIM WITH VA?	6. VA FILE NUMBER					
<input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," provide your file number in Item 6)	092-58-7776					
7A. CURRENT MAILING ADDRESS		7B. FORWARDING ADDRESS					
Street address, rural route, or P.O. Box	Apt. number	Street address, rural route, or P.O. Box					
Heyward, CA. 91523							
City	State	ZIP Code	Country	City	State	ZIP Code	Country
8A. PREFERRED E-MAIL ADDRESS (If applicable)				8B. ALTERNATE E-MAIL ADDRESS (If applicable)			
mheyward@xeraltac.edu							

9. LIST THE DISABILITY(IES) YOU ARE CLAIMING (If applicable, identify whether a disability is due to a service-connected disability, is due to confinement as a Prisoner of War, is due to exposure to Agent Orange, Asbestos, Mustard Gas, Ionizing Radiation, or Gulf War Environmental Hazards, or is related to benefits under 38 U.S.C. 1151).

Please list your contentions below. See the following examples, for more information:

- Example 1: Hearing loss
- Example 2: Diabetes-Agent Orange (exposed 12/72, Da Nang)
- Example 3: Left knee - secondary to right knee

1. Left knee / Lef. Knee	11.	21.
2. Left Calf / Lt. Calf	12.	22.
3. Left thigh	13.	23.
4. - DePress, etc	14.	24.
5. - Lower back	15.	25.
6.	16.	26.
7.	17.	27.
8.	18.	28.
9.	19.	29.
10.	20.	30.

10. LIST VA MEDICAL CENTER(S) WHERE YOU RECEIVED TREATMENT FOR YOUR CLAIMED DISABILITY(IES) AND PROVIDE TREATMENT DATES:

A. NAME AND LOCATION OF VA MEDICAL CENTER	B. DATE(S) OF TREATMENT
S. F. VA Medical Facility 196 Aif	Mar 2012

NOTE: IF YOU WISH TO CLAIM ANY OF THE FOLLOWING DISABILITY COMPENSATION RELATED BENEFITS, COMPLETE AND ATTACH TO THIS FORM THE REQUIRED BENEFIT FORM(S) AS STATED (VA forms are available at [www.va.gov/vaforms](http://www.va.gov/vaforms)).

Benefits for:	Required Form(s):
Dependents	VA Form 21-686c and, if claiming a child aged 18-23 years and in school, VA Form 21-674
Individual Unemployability	VA Form 21-8940 and 21-4192
Specially Adapted Housing or Special Home Adaptation	VA Form 26-4555
Auto Allowance	VA Form 21-4502
Veteran/Spouse Aid and Attendance benefits	VA Form 21-2680 or, if based on nursing home attendance, VA Form 21-0779

## SECTION II: SERVICE INFORMATION

11A. DID YOU SERVE UNDER ANOTHER NAME?	11B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER	
<input type="checkbox"/> YES (If "Yes," complete Item 11B) <input checked="" type="checkbox"/> NO (If "No," skip to Item 12A)	N/A	
12A. I ENTERED ACTIVE SERVICE ON (MM,DD,YYYY)	12B. BRANCH OF SERVICE	12C. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE SERVICE
06/01/1981	Army	08/29/1999
12D. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?	12E. PLACE OF LAST OR ANTICIPATED SEPARATION	
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	Fort Hood TX	
13A. ARE YOU CURRENTLY ACTIVATED TO FEDERAL ACTIVE DUTY UNDER THE AUTHORITY OF TITLE 10, U.S.C. (National Guard)?	13B. DATE OF ACTIVATION (MM,DD,YYYY)	
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes," provide date of activation in Item 13B)	N/A	

14A. WHAT IS THE NAME AND ADDRESS OF YOUR RESERVE/NATIONAL GUARD UNIT? <i>N/A</i>		14B. WHAT IS THE TELEPHONE NUMBER OF YOUR CURRENT UNIT? (Include Area Code) ( )
15A. HAVE YOU EVER BEEN A PRISONER OF WAR? <input type="checkbox"/> YES (If "Yes," complete Item 15B) <input checked="" type="checkbox"/> NO (If "No," skip to Item 16A)		15B. DATES OF CONFINEMENT From: <i>N/A</i> To:
<b>SECTION III: SERVICE PAY</b>		
16A. DID/DO YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE/RETired PAY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "Yes," complete Items 16B and 16C)		16B. LIST AMOUNT (If known) <i>\$ N/A</i> 16C. LIST TYPE (If known) <i>N/A</i>
<p><b>IMPORTANT:</b> Submission of this application constitutes an election of VA compensation in lieu of military retired pay if it is determined you are entitled to both benefits. If you are entitled to receive military retired pay, your retired pay may be reduced by the amount of any VA compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes. Receipt of military retired pay or Voluntary Separation Incentive (VSI) and VA compensation at the same time may result in an overpayment, which may be subject to collection. However, if you do not want to receive VA compensation in lieu of military retired pay, you should check the box in Item 17. Please note that if you check the box in Item 17, you <i>will not</i> receive VA compensation, if granted.</p>		
17. <input type="checkbox"/> I want military retired pay instead of VA compensation.		
<b>SECTION IV: DIRECT DEPOSIT INFORMATION</b>		
<p>The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 18, 19 and 20 to enroll in direct deposit. If you do not have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at <a href="http://www.usdirectexpress.com">www.usdirectexpress.com</a> or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.</p>		
18. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA)		
<input checked="" type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS Account No.: <i>One Record</i>		<input type="checkbox"/> I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT Account No.: _____
19. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit) <i>One Record</i>		20. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check) <i>One Record</i>
<b>SECTION V: CLAIM CERTIFICATION AND SIGNATURE</b>		
<p>I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me, and I waive any privilege which makes the information confidential.</p>		
<p>I certify I have received the notice attached to this application titled, <i>Notice to Veteran/Service Member of Evidence Necessary to Substantiate a Claim for Veterans Disability Compensation and Related Compensation Benefits</i>.</p>		
<p>I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility such as a VA medical center; OR, I have no information or evidence to give VA to support my claim; OR, I have checked the box in Item 21, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.</p>		
<p>21. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will automatically consider a claim submitted on this form for rapid processing under the FDC Program. Check the box below ONLY if you <b>DO NOT</b> want your claim considered for rapid processing under the FDC Program because you plan on submitting further evidence in support of your claim.</p>		
<input type="checkbox"/> I DO NOT want my claim considered for rapid processing under the FDC Program because I plan to submit further evidence in support of my claim.		
22A. VETERAN/SERVICE MEMBER SIGNATURE (REQUIRED) <i>A</i>		22B. DATE/SIGNED <i>9/12/2014</i>
<b>SECTION VI: WITNESSES TO SIGNATURE</b>		
23A. SIGNATURE OF WITNESS (If veteran signed above using an "X") <i>A</i>		23B. PRINTED NAME AND ADDRESS OF WITNESS
24A. SIGNATURE OF WITNESS (If veteran signed above using an "X") <i>A</i>		24B. PRINTED NAME AND ADDRESS OF WITNESS
<p><b>PRIVACY ACT NOTICE:</b> The form will be used to determine allowance to compensation benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.</p>		
<p><b>RESPONDENT BURDEN:</b> We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at <a href="http://www.reginfo.gov/public/do/PRAMain">www.reginfo.gov/public/do/PRAMain</a>. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.</p>		

**ATTACHMENT**

**F**

# Progress Notes

Printed On Sep 16, 2013

LOCAL TITLE: ORTHOPEDIC SURGERY CONSULT H&P  
 STANDARD TITLE: ORTHOPEDIC SURGERY CONSULT  
 DATE OF NOTE: SEP 09, 2013@10:00 ENTRY DATE: SEP 10, 2013@09:07:14  
 AUTHOR: GIORI, NICHOLAS J EXP COSIGNER:  
 URGENCY: STATUS: COMPLETED

PATIENT NAME: HEYWARD, MARCO

**HISTORY:**

The patient is a 49-year-old man who has an interesting history. He fell down some stairs in 2010 and sustained bilateral knee quadriceps tendon ruptures. He was then seen at San Francisco VA where he had bilateral quadriceps tendon ruptures repaired and actually ended up doing quite well with the right side. For reasons that are not clear to me, the left side ended up with a patella baja, but still a healed quadriceps tendon. He is complaining now of some weakness in that left leg, which is probably not surprising given the fact that the patella being not in the right position is probably not giving him the mechanical advantage that he needs. He has also developed some weakness in the quadriceps on that side. He comes in wondering whether he needs to have another operation.

**PHYSICAL EXAMINATION:**

**MUSCULOSKELETAL:** I can definitely feel the quadriceps tendon, which is incontinuity. He is able to do a straight leg raise as well. However, when he walks, he walks with his leg in a locked position. He says that sometimes he feels like his leg is going to give way. I asked him to do straight leg raising exercises, he is able to do 5 relatively easily, but he definitely is weak on the left side compared to the right.

**IMAGING:**

X-rays reveal a patella baja on the left side.

**ASSESSMENT:**

The patient has patella baja subsequent to a quadriceps tendon repair back in 2010. The tendon is now healed, but probably healed in a length and a position leading to a patella baja, which is now scarred down. I told him that there is no specific operation now that would be able to help his condition. Given the fact that he is able to do straight leg raises and walk, he needs to work on strengthening his quadriceps probably beyond what he had previously to make up for the mechanical loss that he had with the change in position of the patella. I demonstrated to him some short squat exercises that do not go very deeply, but still strengthen the quadriceps. He demonstrated understanding and will followup on an as needed basis.

PATIENT NAME AND ADDRESS (Mechanical imprinting, if available)

HEYWARD, MARCO BARREN  
P.O BOX 466  
HAYWARD, CALIFORNIA 94543

VISTA Electronic Medical Documentation

Printed at PALO ALTO HCS

# Progress Notes

Printed On Sep 16, 2013

D: 09/09/2013  
T: 09/09/2013  
Job number: 1160725  
AFF/CMTS  
Send:

/es/ NICHOLAS J GIORI, MD  
STAFF SURGEON, ORTHOPEDIC  
Signed: 09/14/2013 13:56

PATIENT NAME AND ADDRESS (Mechanical Imprinting, if available)

HEYWARD, MARCO BARREN  
P.O BOX 466  
HAYWARD, CALIFORNIA 94543

VISTA Electronic Medical Documentation

Printed at PALO ALTO HCS